

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5521

04167

CERTIFICATE OF DEATH

Reg. Dist. No. 257

1. PLACE OF DEATH: Queen Anne
 County: Queen Anne
 City or town: Centreville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death: 75 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Md County: Queen Anne
 City or town: Centreville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)

3. (a) FULL NAME
 Charles A. Busted

3. (b) Social Security Number

| | | |
|---|------------------|---|
| 4. Sex | 5. Color or race | 8.(a) Single, married, widowed, or divorced |
| Male | White | Widowed |
| 8.(b) Name of husband or wife Mollie G. Busted | | |

7. Birth date of deceased (mo., day, yr.) Oct 31, 1854
 8. (c) If alive, give age years

| | | | | |
|---------|-------|--------|------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | 90 | 5 | 2 | hrs. min. |

9. Birthplace: New South - Caroline Co - Md
 (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Warren R. Busted

| | |
|----------------|------------------|
| 12. Name | Warren R. Busted |
| 13. Birthplace | So Nat Know |

| | |
|-----------------|----------------------|
| 14. Maiden name | Katherine M. Barwick |
| 15. Birthplace | New Sudlersville Md |

18. Informant: Mr J. W. Busted
 Address: 1353 Lubdale Rd - Philadelphia Pa

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Apr 5-45
 Cemetery or crematory: Chesterfield

Location: Centreville, Md

18. Funeral director: Barton Bros.

Address: Centreville, Md

19. Date rec'd by registrar: Apr 4 - 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-2-45 at 2:55

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 4-2 1945

and that I last saw him alive on 4-2 1945

Immediate cause of death: Rubbing J C
met.

DURATION

Due to: Rubbing

Due to: Rubbing

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: Date of op.

Autopsy results: Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

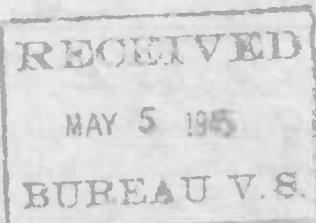
Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. M. Thompson M. D. or other

Date signed: 4-3-45

Address: Centreville, Md



PLEASE WRITE PLAINLY; WITH UNFADING INK.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04168

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County..... Queen Anne
 City or town..... Sudlersville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary S. Chance

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.) Sept 25 - 1865

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
79 8 27 hrs. min.

9. Birthplace..... Q. A. Co. (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... John E. Chance

13. Birthplace..... Q. A. Co.

14. Maiden name..... Harriett Phillips

15. Birthplace..... Q. A. Co.

16. Informant..... Mr. Chas. Chance

Address..... Sudlersville Md
Burial Date thereof..... April 24-45
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory..... Sudlersville

Location..... Sudlersville Md

18. Funeral director..... Edg. L. Lane

Address..... Church Hill

19. April 25 1945 Edgar L. Lane
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne
 City or town..... Sudlersville
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 21 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1944 to April 21 1945

and that I last saw her alive on April 20 1945

Immediate cause of death..... Ruborrheal Hemorrhage

Virus Pneumonia

Due to..... Ruborrheal Hemorrhage

Due to..... Ruborrheal Hemorrhage

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings at operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... C. H. Wilcoffe M. D. or other

Address..... 5th Street & 2nd Date signed..... April 25 1945

RECEIVED

APR 28 1945

BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04169

1. PLACE OF DEATH

County

Green Ave

9421

Registration Dist. No. 253

St.

Ward

Village or City

Stevensville

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No.

4213 Harcourt Rd St.

Ward.

Baltimore ✓

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Lillie Mae Coughlin

6. DATE OF BIRTH (month, day, and year)

10-15-1893

7. AGE

51

Years

5

Months

17

Days

17

If LESS than

1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)3-31
4511. Total time (years)
spent in this
occupation
years

Marinist

12. BIRTHPLACE (city or town)
(State or country)

Baltimore

MOTHER FATHER

13. NAME

Joseph Coughlin

14. BIRTHPLACE (city or town)
(State or country)

Baltimore Mass

15. MAIDEN NAME

Julie Lawrence

16. BIRTHPLACE (city or town)
(State or country)

Baltimore Md

17. INFORMANT

Lillie Mae Coughlin

(Address)

Stevensville Md

18. BURIAL, CREMATION, OR REMOVAL

Place

Oak Lnn

Date April 5

1945

19. UNDERTAKER

John C Moran

(Address)

3000 E Baltimore St

20. FILED

April 1, 1945

Registrar.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No

If so, specify

(Signed)

(Address)

Lucy Bui M.D.

Deputy Medical Examiner

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

| | |
|--------------------------------|---------------|
| Arteriosclerosis | Date of onset |
| Chronic interstitial nephritis | 1915 |
| Cerebral hemorrhage | 1921 |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B.R.)*

04170

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County *Queen Anne's*
 City or town *Bethesda* *Melington*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 mds.*Hospital, institution, or street address where death occurred: *Palmatory Nursing Home*How long in hospital or institution? *3 mds.*

3. (a) FULL NAME

Elizabeth Dewberry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female *White* *Widowed*
Thomas Dewberry

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 4. 1873

8. AGE:

Years

Months

Days

If less than one day

*72**0**22**hrs.**min.*

9. Birthplace

(Town, county, and state)

Queen Anne's Co. Md.

10. Usual occupation

Housewife

11. Industry or business

12. Name

Thomas Austin

13. Birthplace

Talbot Co. Md.

14. Maiden name

Sarah E. Tucker

15. Birthplace

Unknown

16. Informant

Mrs. Martha Richards

Address

Church Hill Md.

17. Burial

(Burial, cremation, or removal. Which?)

*Date thereof April 29-1945**(month) (day) (year)*

Cemetery or crematory

Crompton Cemetery

Location

Crompton Md.

18. Funeral director

Edgar L. Lane

Address

Church Hill Md.

19. Date rec'd by registrar

April 27 1945

(Date rec'd by registrar)

Edgar L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Queen Anne's*
 City or town *Church Hill*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

*April 26**1945 at 10 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1945 to April 26 1945
 and that I last saw her alive on *April 24* 1945

Immediate cause of death

Pneumonia

DURATION

4 years

Due to

*Hypoglycemia**1941*

Due to

*Auto accident**1928*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

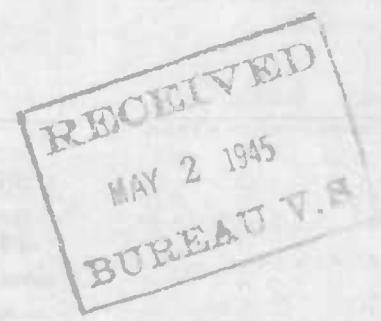
Hammond

M. D. or other

Address

April 27 1945, Melington

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63

CERTIFICATE OF DEATH

Dr Price
04171
Reg. Dist. No. 254

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Hattie R. Griffin

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Colored Married
6.(b) Name of husband or wife..... Charles Griffin

7. Birth date of deceased (mo., day, yr.)

Sept-13-1885

6.(c) If alive, give age 65 years

8. AGE:

Years

Months

Days

If less than one day

59-

6 29

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

Joseph Price
Car朋ebael Md

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

Rebecca Glasgow
Car朋ebael MdAlbert Griffin
Baltimore 10 recd

Burial Date thereof APR 13 1945

John Wesley Chapel Cemetery
Car朋ebael MdJohn D. Williams
Baltimore 10 recd

Faison Yards

4-13 1945 H. M. Aldridge
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD

County..... Car朋ebael

City or town..... Carmichael

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 11-1945 at 1245 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1945, to April 11, 1945,

and that I last saw her alive on March 31, 1945.

Immediate cause of death.....

Exsanguination due to
Hyper-Hypotension

DURATION

5 hrs

Due to.....

Due to.....

Other conditions.....

Metabolic reperfusion
arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

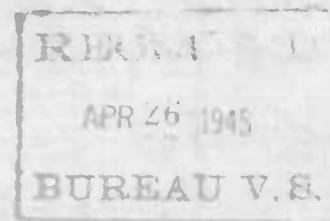
Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Samuel J. Price, M.D.
4-13-45 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04172

251

Reg. Dist. No....

1. PLACE OF DEATH:

County..... Queen Anne
City or town..... Church Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Julia M. Payne

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Fem. White Widowed

6.(b) Name of husband or wife.....

Bowers Payne

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 24 - 1863

8. AGE:

| | | | |
|-------|--------|------|----------------------|
| Years | Months | Days | If less than one day |
| 82 | 1 | 10 | hrs. min. |

9. Birthplace..... Queen Anne Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

12. Name..... Mrs. R. Hollingsworth

13. Birthplace..... Queen Anne Co. Md.

14. Maiden name..... Ellen Birake

15. Birthplace..... Queen Anne Co. Md.

16. Informant..... Mrs. Mae Jester

Address

Church Hill Md.

17. Burial.....

Date thereof..... April 5-1945
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory..... Centerville Cem.

Location..... Centerville Md.

18. Funeral director..... Edgar S. Lane

Address

Church Hill Md.

19. Death..... April 4 1945
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... Church Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3 1945 A.M.

21. I CERTIFY that death occurred on the date above stated: that attended deceased from

April 7 1945 to April 8 1945

and that I last saw her alive on April 8 1945

Immediate cause of death.....

Stroke at the severance 10 days

Due to..... cerebral hemorrhage 7 days

Due to..... hypertension 10 days

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

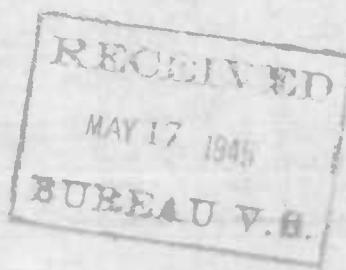
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Church Hill

Date signed..... April 13 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 26A

04173

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH:

County.....

Anne Arundel County

City or town.....

Millington Town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

4 1/2 weeks

Hospital, institution, or street address where death occurred:.....

Mrs. Paluatory's Refugior

How long in hospital or institution?.....

4 1/2 weeks

3. (a) FULL NAME

Susan Amanda Porter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fem

Whit

single

B. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Oct 2 1864

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

80

5

7

hrs.

min.

B. Birthplace.....

Kent Co. Md.

(Town, county, and state)

10. Usual occupation.....

House work

11. Industry or business

own

12. Name.....

John Henry Porter

13. Birthplace

Kent Co. Md

14. Maiden name.....

Rachel Moffett

15. Birthplace

Kent Co. Md.

16. Informant.....

Rev. George Collier

Address

Rock Hall, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof APRIL 12 1945

(month) (day) (year)

Cemetery or crematory

Wesley Chapel

Cem.

Location

Near Rock Hall, Md.

18. Funeral director.....

J. Willis WELLS

Address

CHESTERTOWN, Md.

19. Date rec'd by registrar

April 10 1945

Edgar S. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Rock Hall, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 9

1945 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4 1945 to April 9 1945

and that I last saw her alive on 3-5 1945

Immediate cause of death.....

Fractured R. hip
from Endo-myocarditis

Due to.....

Endo-myocarditis

DURATION

Due to accidental fall - slipped on ice.

C. L. G.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Accident January 4, 1945

Where did injury occur?

(City or town)

Maryland (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert R. Burgard

M. D. or other

Address

Rock Hall, Md.

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04174

M

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County..... Queen Anne's County

City or town..... Sdersvilles

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bertha Richter

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

fam.

Whil

Married

6.(b) Name of husband or wife

Anthony Richter

7. Birth date of deceased (mo. day, yr.)

Nov. 25 1901

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

44

1

20

hrs.

min.

9. Birthplace

Jagovlatvia

(Town, county, und state)

10. Usual occupation

housewife

11. Industry or business

own home

MOTHER FATHER

12. Name

Josephine Bures

13. Birthplace

Jagovlatvia

14. Maiden name

Edithaeller Fer

15. Birthplace

Jagovlatvia

16. Informant

Anthony Richter

Address

Sdersvilles

17. Burial

Date thereof April 16 1945

(Burial, cremation, or removal. Which?)

(Month) (day) (year)

Cemetery or crematory

Church Hill Cem.

Location

Church Hill Ind.

18. Funeral director

Edgar L. Lane

Address

Church Hill Ind.

19. April 15 45

19 Edgar L. Lane

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... Sdersvilles

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 13 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1944 to April 13 1945

and that I last saw her alive on April 13 1945

Immediate cause of death

Bronchitis

bronchopneumonia

Due to Dr. George F. O'Callaghan

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

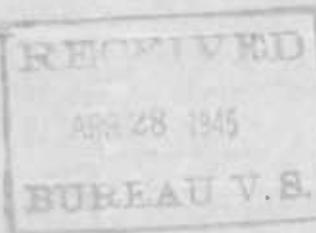
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE acarrel Burgard M. D. or other

Address Rock Hall, Md. Date signed 7/1/75



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

Reg. Dist. No.

04175
254

1. PLACE OF DEATH:

County..... Queen Anne
City or town..... Grasonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

George Samson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Colored Married

6.(b) Name of husband or wife..... Louise Griffin Samson

about 56

years

7. Birth date of deceased (mo., day, yr.)

April 10 - 1888

8. AGE:

| | | | |
|-------|--------|------|----------------------|
| Years | Months | Days | If less than one day |
| 57 | 0 | 12 | hrs. min. |

9. Birthplace.....

Queen Anne Co. Md.

(Town, county, and state)

10. Usual occupation.....

Farm Labourer

11. Industry or business

MOTHER FATHER

12. Name..... Don't know

13. Birthplace..... Don't know

MOTHER MOTHER

14. Maiden name..... Mary Murray

15. Birthplace..... Queen Anne Co Md

16. Informant..... Louise Griffin Samson

Address..... Grasonville Md.

17. Burial.....

(Burial, cremation, or removal which?) Cemetery or crematory.....

Date thereof..... Apr. 26-45 (month) (day) (year)

Location..... Chesapeake

Chestertown Maryland

18. Funeral director.....

Address..... Burton Bros

19. Date of death..... April 26 45

(Date filed by registrar) 19. N.M. Aedridge

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... Grasonville
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4 - 24 1945 at..... M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 18 1945 to 4-24 1945 and that I last saw h. m. alive on 6-20 1945.

Immediate cause of death.....

Chronic Pulmonary Disease
of the heart.

DURATION

Due to.....

Pulmonary P. D. D.

Due to.....

Hypertension

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

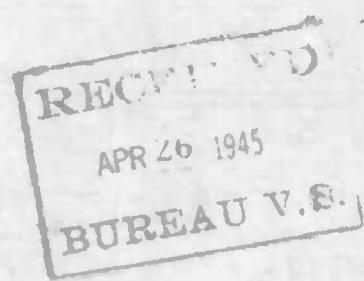
Means of injury.....

Injured at work?

23. SIGNATURE..... H. S. McPherson

M. D. or other.....

Address..... Chestertown, Md. Date signed..... 4-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

04176

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

Florence Taylor

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F

W

Single

6.(b) Name of husband or wife.....

Single

7. Birth date of deceased (mo., day, yr.)

July 5, 1859

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Philadelphia Pa.

(Town, county, and state)

10. Usual occupation.....

Retail Merchant Beyer

11. Industry or business

MOTHER FATHER

12. Name.....

Jackie Arially Taylor

13. Birthplace.....

Baltimore W. Md.

14. Maiden name.....

Petilia Parry

15. Birthplace.....

Philadelphia Pa.

16. Informant.....

Mrs Temperance Faquette

Address

Burial

Faithfully夫

(Burial, cremation, or removal. Which?)

Date thereof April 18-19 45

(month) (day) (year)

Cemetery or crematory.....

Woodland Cem.

Location

Phila. Pa.

18. Funeral director.....

Edgar L. Lane

Address

Church Hill Ind.

19. April 15 1945

Edgar L. Lane

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Pennsylvania County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 15 1945 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1944 to April 15 1945

and that I last saw her alive on April 14 1945

Immediate cause of death.....

Acute Dilatation of Heart

DURATION

Due to..... Chronic Myocarditis

Due to..... CH Hypertension

Other conditions.....

Feverish

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

C H Whitehead M.D.

M. D. or other

Address.....

Faithfully夫

Date signed April 15 1945

RECEIVED
APR 28 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04177

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County.....*Queen Anne's*
 City or town.....*Rural Centerville*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary C. Wilson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Female Colored married*B. (b) Name of husband or wife.....*George H. Wilson*

7. Birth date of deceased (mo., day, yr.)

Sept. 18 - 1901

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

43 6 20 hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Brown

12. Name.....

*Mary**Blakes*

13. Birthplace.....

Maryland

14. Maiden name.....

Mary Alice Blakes

15. Birthplace.....

Maryland

16. Informant.....

Mrs. George H. Wilson

Address

Centerville R. F. D.

17. Burial.....

(Burial, cremation, or removal. Which?)

April 11-1945

(month) (day) (year)

Cemetery or crematory.....

Rossville Cemetery

Location.....

Rossville Md.

18. Funeral director.....

Edgar L. Lane

Address

Church Hill Md.

19. April 8 1945

(Date rec'd by registrar)

E. L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Queen Anne's*City or town.....*near Centerville*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*April 7 th 1945* at 0.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to

and that I last saw h..... alive on

Immediate cause of death.....

Coronary Occlusion

DURATION

, day

Due to.....*No physician seen*Due to.....*after stroke 2 years*

or more.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

No

Date of op.....

Autopsy results.....

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....*No* Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE.....*Samuel J. Price MD* M. D. or otherAddress.....*Deputy medical examiner* Date signed *4/7/45*

